DUQUESNE UNIVERSITY

Annual Health Screening Questionnaire for History of Positive TB Skin or Blood Test

Instructions: Annual symptom screening is required for all students who have a history of a positive tuberculosis skin test (PPD skin test) or a positive IGRA/Q Gold/T-Spot (TB blood test). Students are required to complete this form yearly only if they have a history of a positive TB skin or blood test.

When did you convert to a positive PPD or blood test?

_____

What is the date of your last chest x-ray?_____

Result: _____

Do you CURRENTLY have symptoms of:

	YES	**NO**
Weight loss (unrelated to dieting)	□	□
Loss of appetite for >2 weeks	□	□
Bloody sputum	□	□
Night sweats/fever	□	□
Unusual fatigue for > 2 weeks	□	□
Persistent cough > 2 weeks	□	□

Answering "yes" to any of the above questions constitutes a positive screening evaluation and requires further follow-up with your health care provider.

I am aware that misrepresentation of health information may result in dismissal from the program. I declare that my answers and statements are correctly recorded, complete, and true to the best of my knowledge.

Signature_____ **Date**_____

Print Name _____ **Student ID#**_____

Health Care Provider verifying information [THIS FORM MUST BE SIGNED BY A HEALTH CARE PROVIDER] Nurse Practitioner, Physician, Registered Nurse, Physician's Assistant or a public health official	
Name of Health Care Provider [Print]	**Telephone [area code + number]**
Signature of Halth Care Provider	**Date**
Address of Health Care Provider	